

Effect of Sudarshan Kriya on male prisoners with non psychotic psychiatric disorders: A randomized control trial



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ABSTRACT

Objectives: To investigate whether Sudarshan Kriya and related practices (SK&P) can lead to increased global assessment of functioning (GAF) and increased feeling of wellness in male prisoners with a non psychotic psychiatric disorder.

Methodology: This is a six month parallel randomized controlled study with sample size of 230 male prisoners. Participants meeting inclusion and exclusion criteria were assigned to a study or control group by simple random allocation in which random allocation sequence was generated using a random number table. Each individual study participant was involved in a daily program of SK&P for six weeks. Each individual control participant was instructed to sit in an armchair with his eyes closed and gentle attention to their breath for duration of six weeks. To be included in this study, a participant must be a male prisoner diagnosed to be suffering from a psychiatric disorder (except psychosis and bipolar affective disorder [BPAD]) by ICD-10 (DCR) criteria with age between 18 and 65 years.

Results: Majority of subjects were unemployed married individuals, educated until undermatric level and not having occupational skills of more than an unskilled labor level. Practicing SK&P for six weeks led to improvement in mean \pm SD score of study participants in GAF, anxiety (ANX), depressed mood (DEP), positive well being (PWB), general health (GH), self control (SC), vitality (VT) and total positive general well being (PGWB). Change in mean \pm SD score of study participants when compared with control participants was statistically significant in terms of GAF, ANX, DEP, PWB, GH and PGWB. Increase in SC and VT scores was statistically insignificant when compared with control participants.

Conclusion: Practicing SK&P helps in improving GAF, PWB, GH and total PGWB of an individual. SK&P also causes significant reduction in anxiety and depression levels. Effect of SK&P on SC and VT is insignificant.

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1. Introduction

Sudarshan Kriya Yoga (SKY) is a multi-component program that includes yoga movement, breathing, meditation techniques, group processes and yoga philosophy (Janakiramaiah et al., 2000). Sudarshan Kriya and related practices (SK&P) includes (1) three stage slow resistance breathing (Ujjayi), (2) bellows breath (Bhastrika) a high frequency forceful breathing technique, (3) om chant, (4) Sudarshan Kriya, (SK) and (5) alternate nostril breathing (ANB) (Brown et al., 2013). This breathing technique is practiced by millions worldwide. It is claimed to be effective in

improving well being and peace of mind. In practitioners of SK&P, significant increase in mental alertness (beta activity) was observed in the left frontal, parieto-occipital and midline regions of the brain, as compared to controls (Bhatia et al., 2003). Practitioners of SK&P were found to have significantly greater antioxidant production and lower blood lactate levels which might be one of the contributing reasons of greater resilience to daily life stress as noticed in SK&P practitioners (Sharma et al., 2003).

SK&P has been most widely studied in depression; upon practicing SK&P, 68% dysthymic patients (Bhatia et al., 2003) and 73% patients suffering from melancholic depression (Naga Venkatesha Murthy et al., 1998) showed remission. SK&P takes three weeks in showing its antidepressant effects (Naga Venkatesha Murthy et al., 1998) and in patients suffering from dysthymia and melancholic depression after 90 days of using SK&P, P300

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Evoked response potential (ERP) amplitude readings return to normal (Naga Venkatesha Murthy et al., 1997). SK&P although inferior to electro-convulsive therapy (ECT) can be a potential alternative to drugs in melancholia as a first line treatment (Janakiramaiah et al., 2000). Due to its advantage of fostering the patient's autonomy and self reliance SK&P is likely to be a more acceptable and efficacious alternative to medical management of dysthymia for both acute treatment and relapse prevention. It also has the advantage of cutting health care costs (Janakiramaiah and Gangadhar, 1998).

The practice of SK&P has been found to reduce tension and anxiety. The autonomic symptoms of high anxiety such as headache, dizziness, chest pain, palpitations, sweating and abdominal pain respond well (Boyd, 1995). Benefits of SK&P as potentially valuable adjunct to standard pharmacotherapy is also proven in patients with generalized anxiety disorder (GAD) or treatment resistant GAD (Katzman et al., 2012) and PTSD (Carter et al., 2013). PTSD from sexual abuse benefits when SKY breathing is combined with traditional psychiatric and psychological therapies (Sageman, 2004) though its independent effectiveness still needs to be proven.

SK&P is also effective in mass disaster (Descilo et al., 2010) and increasing longevity (Brown and Gerberg, 2009).

Though efficacy of SK&P has been proven in multiple disorders and situations, comparing various studies so far has been difficult due to variable expertise of therapist, sampling techniques, geographical variations, daily time spent in doing SK&P, use of controls and the time period of the study.

The current study is an attempt to evaluate effectiveness of SK&P in a prison population.

2. Objective

To investigate whether SK&P can lead to increased GAF and increased feeling of wellness in male prisoners with non psychotic psychiatric disorder.

2.1. Materials and methods

This is a parallel randomized controlled study. The study was conducted at Central Jail Hospital (CJH), New Delhi which is the largest prison hospital setting in India with both inpatient and outpatient departments. During the study period of six months (between 11/1/13 and 10/7/13) participants were enrolled in and randomly assigned to either a six-week SK&P intervention or a six week comparison control group. The study was approved by the Ethics review committee of CJH. Randomization was done using simple random allocation in which random allocation sequence was generated using a random number table. One investigator uninformed in the treatments or assessments generated random numbers for 232 male prisoners to be allocated to two groups in equal numbers with allocation ratio of 1:1. All male prisoners admitted in Central Jail (CJ) fulfilling study criteria were taken. The sample size was decided on the basis of the number of male prisoners suffering from non psychotic psychiatric disorder admitted in CJ for more than six weeks in the previous year.

Each individual study participant was involved in a program of SK&P which he practiced daily for six weeks. Each individual control participant daily sat on an armchair with his eyes closed and gentle attention on his breath for duration of six weeks. Two certified SK&P teachers (trained to lead sessions at Art of Living) taught the procedure to all participants throughout the course of treatment. Only SK&P therapists involved in the study were informed to start the corresponding intervention; the rest of the research team were unaware of the current group allocation. All

participants signed consent forms and they were treated according to the ethical guidelines of Helsinki in 1995 (as revised in Edinburgh 2000). Participants at time of inclusion in the study signed an informed consent form. At time of inclusion in the study, participants were clearly explained that practicing SK&P is part of the research project and that they will continue to receive pharmacological therapy during the course of the study. They were also explained that they are free to drop out of the study at any point of time without any penalty or impact on pharmacological treatment. The assessment tools were applied in the order starting from the Basic Socio-demographic Proforma, mini-mental state examination (MMSE), schedule for clinical assessment in neuropsychiatry (SCAN) based clinical interview, Global assessment of functioning (GAF) and Psychological general well being (PGWB). These assessments were conducted in all participants before starting the intervention and six weeks thereafter. Confidentiality and privacy were maintained throughout the assessment process.

Assessment of all participants took place in the Psychiatry ward of CJH. As pre-decided, the trial was stopped after six months due to non availability of trained therapists. SK&P sessions were continued by some group volunteers who were trained to take SK&P sessions.

Inclusion criteria for participants:

- (1) Having an interest in SK&P in that they would like to practice it daily for 6 weeks.
- (2) Age between 18 and 65 years.
- (3) Male prisoners diagnosed to be suffering from a psychiatric disorder (except psychosis and BPAD) by ICD-10 (DCR) criteria.
- (4) Patient willing to give written informed consent.

Exclusion criteria for participants:

- (1) History of substance dependence in past one year.
- (2) Prisoners with co-morbid severe physical illness (like hepatic encephalopathy, severe debilitating illness) that might have hampered the assessment process.
- (3) Prisoners with severe cognitive deficits that might have hampered the assessment process. Prisoners with MMSE score of less than 23 were excluded from the study.

Procedure followed during SK&P (Brown and Gerberg, 2005a): In Study participants SK&P components were applied in order of (1) three staged Ujjayi breathing, (2) bellows breath (Bhastrika), (3) om chant, (4) SK and (5) ANB. The breathing practices were done in a sitting posture on the floor. Eyes and mouth were kept closed while breathing through the nose throughout the sessions.

Three stage Ujjayi is a slow, deep resistance breathing technique with respiratory rate of 4–6 breaths per minute. This is accomplished by a slight voluntary contraction of the laryngeal muscles and partial closure of the glottis to increase airway resistance and breath control. Each breath cycle is timed with counts of four during inhalation, four holding the breath, six during exhalation, and two holding the breath. Supplementary instructions were given in three stages that included specific breath cycle ratios, extended expiration duration with shortened inspiration, distinct arm postures, and breath-holds, all of which served to augment the effects of this particular breathing technique. During SK&P this is practiced for approximately eight minutes. Ujjayi tends to be calming and to produce a sense of well-being.

Bhastrika involves forceful rapid deep breathing through the nose at a rate of 20 to 30 breaths per minute. Three one minute rounds of Bhastrika are each followed by 30 seconds of normal breathing. Arm movements are used to increase the force and depth of respiration. This breathing exercise was practiced for approximately five minutes.

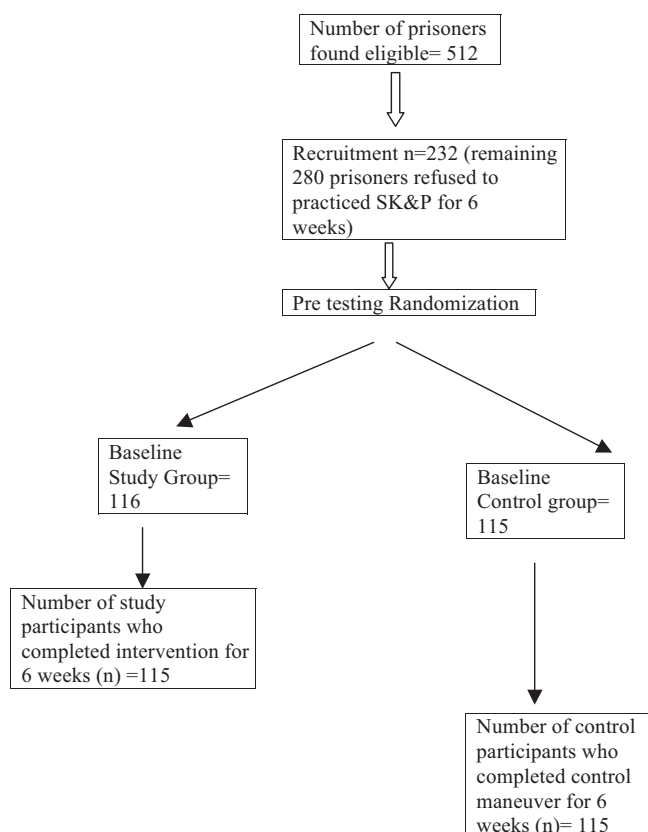


Fig. 1. Flowchart of steps followed in study.

Next, the participants engaged in the prolonged chanting of the sound 'om' which creates vibrations in the abdomen, chest, throat and jaw. 'Om' was chanted three times.

SK involves rhythms, cyclical forms of breathing in which there are no pauses between inhalation and exhalation. SK involves multiple rounds of slow (8–14 respiratory cycles per minutes), medium (40–50 respiratory cycles per minute) and fast (60–100 cycles per minute) cycles with varying rhythms and intensities; SK lasts about ten minutes.

ANB was practiced for five minutes.

As part of the study daily spending 30 minutes in doing SK&P was mandatory for all study participants. After the session, an hour was spent by the therapist correcting flaws in SK&P technique of various participants, which were either noticed by the therapist during the session or brought to his/her notice by an individual participant.

For a similar duration of 30 minutes the control participants were instructed to sit in an armchair with their eyes closed and gentle attention focused on the breath (Fig. 1).

2.2. Instruments used in study

- 1. Basic Socio-demographic Performa:** Socio-demographic characteristics such as age, sex, marital status, education, occupation, employment status, religion, residence and family history of psychiatric illness and substance/alcohol use were recorded.
- 2. The mini-mental state examination (MMSE):** The MMSE is a 30-point questionnaire test designed by Folstein et al. (1975) and is used to rule out cognitive deficits in the participants.
- 3. Global assessment of functioning scale (GAF):** The GAF is a 100 point scale designed by Luborsky et al. which is divided into 10 equal 10 point intervals. Patients with 81–90 and 91–100 intervals exhibit superior functioning; 71–80 intervals are for persons with minimal psychopathology. Most patients in

outpatient settings will receive ratings between 31 and 70 and most inpatients between 1 and 40 (Hall, 1995).

- 4. Psychological general well being schedule (PGWB):** The PGWB scale developed by (Dupuy, 1984) has 22 items that are aggregated to provide scores in six subscales. The scale, a self administered questionnaire, includes both positive and negative questions with a time frame and a six point response representing intensity or frequency for the first 14 questions. The last four questions use a 0 to 10 rating.
- 5. Schedule for clinical assessment in neuropsychiatry (SCAN):** The assessment of the psychiatric morbidity in the participants was performed by a SCAN based clinical interview in which the clinical interview was conducted on line with various sections of the SCAN to enhance the thoroughness of the clinical interview (World Health Organization, 1998).

Wherever required for better clarification, additional information from clinical records and staff observations were incorporated into the assessment process.

3. Statistical analysis and data collection

Data was entered in the data based computer program and analyzed using the statistical package for social sciences (SPSS 15.0.1) (Levesque, 2007). Descriptive (frequency and percentage) and inferential statistics (Chi-square test, *t*-test and Cohen's effect size) were used to interpret the data.

4. Results

In Table 1, mean age for the study participants was 35.7 years ($SD = 10.17$); for the control group $M = 36.4$ years, $SD = 12.67$. Difference between age of study and control participants was not statistically significant ($p = 0.64$, $t = 0.46$, Cohen's $d = -0.06$). p value of <0.05 was considered as statistically significant.

According to Table 2, the majority of patients in both study and control groups had education level of undermatric or below, were married unemployed males, and had occupational skills of unskilled worker or below. Difference between socio-demographic variables in the study and control participants was not statistically significant. A p value of <0.05 was considered as statistically significant.

According to Table 3, depressive episode/recurrent depressive episode (RDD) was the most common disorder in both study (34.5%) and control (36.2%) participants. Adjustment disorder (17.2%) in study participants and GAD (19%) in control participants were the second most common disorder in the respective groups. No statistical difference between study and control participants in terms of psychiatric disorders was found ($\chi^2 = 2.25$, $dof = 4$, $p = 0.69$); p value of <0.05 was considered as statistically significant.

According to Table 4, after 6 weeks of SK&P mean GAF scores in study participants increased from 48.1 ± 18.33 to 59.67 ± 21.10 . In the same period mean GAF scores in control participants decreased from 53.42 ± 19.13 to 52.28 ± 19.81 .

According to Table 5, practicing SK&P for six weeks by study participants lead to an increase in mean score of total PGWB and

Table 1
Socio-demographic profile of study and controls participants I.

| | N | Minimum | Maximum | Mean \pm SD |
|--------------------------------------|-----|---------|---------|------------------|
| Age of participants in years | 116 | 21.5 | 63.8 | 35.7 \pm 10.17 |
| Age of control participants in years | 116 | 21 | 64.3 | 36.4 \pm 12.67 |

Table 2
Socio-demographic variables of study and control participants II.

| | | Number of study participants (n = 116) | Percentage (%) | Number of control participants (n = 116) | Percentage (%) | Chi-square test | dof | p |
|----------------|--------------------|--|----------------|--|----------------|-----------------|-----|------|
| Education | Illiterate | 37 | 31.9 | 32 | 27.6 | 3.27 | 3 | 0.35 |
| | Undermatic | 44 | 37.9 | 39 | 33.6 | | | |
| | Higher Secondary | 18 | 15.5 | 29 | 25 | | | |
| | Graduate and above | 17 | 14.7 | 16 | 13.8 | | | |
| Occupation | No occupation | 28 | 24.1 | 31 | 26.7 | 0.712 | 5 | 0.98 |
| | Unskilled worker | 34 | 29.3 | 30 | 25.9 | | | |
| | Skilled worker | 24 | 20.7 | 26 | 22.4 | | | |
| | Professional | 10 | 8.6 | 11 | 9.5 | | | |
| | Business | 12 | 10.3 | 10 | 8.6 | | | |
| | Student | 8 | 6.9 | 8 | 6.9 | | | |
| Employment | Unemployed | 67 | 57.76 | 64 | 55.17 | 0.16 | 1 | 0.69 |
| | Employed | 49 | 42.24 | 52 | 44.83 | | | |
| Marital status | Married | 60 | 51.72 | 66 | 56.90 | 0.64 | 2 | 0.73 |
| | Unmarried | 42 | 36.2 | 38 | 32.76 | | | |
| | Separated/widowed | 14 | 12.07 | 12 | 10.34 | | | |

p value less than 0.05 considered statistically significant.

Table 3
Prevalence of various psychiatric disorders in study and control participants.

| Psychiatric disorder | Number of study participants (n = 116) | Percentage (%) | Number of control participants (n = 116) | Percentage (%) |
|--|--|----------------|--|----------------|
| Obsessive compulsive disorder | 14 | 12.1 | 14 | 12.1 |
| Generalized anxiety disorder | 14 | 12.1 | 22 | 19 |
| Depressive episode/recurrent depressive disorder | 40 | 34.5 | 42 | 36.2 |
| Somatoform disorder | 16 | 13.8 | 12 | 10.3 |
| Adjustment disorder | 20 | 17.2 | 16 | 15.5 |
| Habit and impulse disorder | 12 | 10.3 | 10 | 6.9 |

various subgroups. In the same period the mean score of control participants [except SC (8.01 ± 4.52) and total PGWB (40.91 ± 27.44)] also increased but this increase was much less than for the study participants.

According to Table 6, on completion of six weeks change in mean + SD score of study participants when compared with control participants was statistically significant ($p < 0.05$) in terms of GAF, ANX, DEP, PWB, GH and PGWB. Though there was an increase in SC and VT scores the increase was insignificant when compared with control participants.

There were no safety issues. During the course of the study, one dropout occurred in both the SK&P and control groups; both dropouts occurred because participants got released from prison.

5. Discussion

The period for doing SK&P was set at six weeks because, according to an earlier study, the percentage of patients

experiencing remission in depression after initiation of SK&P was similar at one month and three months (Janakiramaiah and Gangadhar, 1998). Also, neither the severity of depression nor the severity of biological dysfunction influenced the quick response time or degree of effectiveness of SK&P. The antidepressant effect of SK&P was exerted in about three weeks (Naga Venkatesha Murthy et al., 1998).

Cases with severe medical co-morbidity were excluded because patients with lung disease, asthma, hernia, recent surgery, recent myocardial infarction, high blood pressure, cerebral vascular disease, or migraine may not tolerate holding their breath, *Bhastrika*, or head-down postures (Brown et al., 2009). Also, practicing unmodified *pranayama* can lead to the risk of seizures occurring in patients with epilepsy (Yardi, 2001). Prisoners suffering from psychosis and BPAD were not included in study as an earlier study had stated that incorrect techniques or the overuse of SK&P beyond the prescribed time limits can cause dizziness, lightheadedness, irritability, euphoric states, or

Table 4
Global assessment of functioning (GAF) score.

| Score Range | Baseline number of study participants (n = 116) | Post intervention number of study participants (n = 115) | Baseline number of control participants (n = 116) | Post 6 weeks number of control participants (n = 115) |
|-------------|---|--|---|---|
| 0–10 | 0 | 0 | 0 | 0 |
| 11–20 | 5 | 0 | 0 | 0 |
| 21–30 | 19 | 12 | 18 | 20 |
| 31–40 | 18 | 13 | 11 | 13 |
| 41–50 | 22 | 16 | 26 | 26 |
| 51–60 | 23 | 17 | 20 | 20 |
| 61–70 | 14 | 19 | 18 | 14 |
| 71–80 | 10 | 16 | 12 | 8 |
| 81–90 | 5 | 13 | 8 | 11 |
| 91–100 | 0 | 9 | 3 | 3 |
| Mean ± SD | 48.1 ± 18.33 | 59.67 ± 21.10 | 53.42 ± 19.13 | 52.28 ± 19.81 |

Table 5
Psychological general well being schedule (PGWB) score.

| Dimensions | Score range | Baseline number of study participants (n = 116) | Post intervention number of study participants (n = 115) | Baseline number of control participants (n = 116) | Post 6 weeks number of study participants (n = 115) |
|----------------------|---------------------------|---|--|---|---|
| Anxiety (ANX) | 0–5 | 40 | 21 | 38 | 36 |
| | 6–10 | 28 | 13 | 28 | 27 |
| | 11–15 | 22 | 19 | 20 | 21 |
| | 16–20 | 18 | 33 | 19 | 20 |
| | 21–25 | 8 | 29 | 11 | 11 |
| | Mean ± SD | 9.64 ± 6.79 | 14.47 ± 7.45 | 10.12 ± 7.07 | 10.37 ± 7.07 |
| Depressed Mood (DEP) | 0–5 | 40 | 17 | 42 | 42 |
| | 6–10 | 38 | 46 | 42 | 40 |
| | 11–15 | 38 | 52 | 32 | 33 |
| | Mean ± SD | 7.74 ± 4.57 | 9.45 ± 4.00 | 7.39 ± 4.46 | 7.43 ± 4.50 |
| | Positive well being (PWB) | 0–5 | 32 | 18 | 36 |
| | 6–10 | 30 | 14 | 24 | 26 |
| | 11–15 | 28 | 31 | 34 | 36 |
| | 16–20 | 26 | 52 | 22 | 22 |
| Mean ± SD | 9.93 ± 5.96 | 13 ± 5.85 | 9.66 ± 5.95 | 10 ± 5.79 | |
| Self control (SC) | 0–5 | 40 | 29 | 36 | 38 |
| | 6–10 | 38 | 26 | 40 | 41 |
| | 11–15 | 38 | 60 | 40 | 36 |
| | Mean ± SD | 7.74 ± 4.57 | 9.22 ± 4.65 | 8.01 ± 4.52 | 7.75 ± 4.49 |
| | General health (GH) | 0–5 | 40 | 19 | 38 |
| | 6–10 | 38 | 40 | 40 | 41 |
| | 11–15 | 38 | 56 | 38 | 39 |
| Mean ± SD | 7.74 ± 4.57 | 9.53 ± 4.16 | 7.84 ± 4.52 | 8.02 ± 4.49 | |
| Vitality (VT) | 0–5 | 30 | 20 | 28 | 20 |
| | 6–10 | 28 | 18 | 26 | 22 |
| | 11–15 | 30 | 39 | 32 | 37 |
| | 16–20 | 28 | 38 | 30 | 36 |
| | Mean ± SD | 10.28 ± 6.01 | 12.04 ± 5.72 | 10.64 ± 5.96 | 11.78 ± 5.71 |
| | Total | 0–10 | 16 | 7 | 18 |
| 11–20 | | 14 | 6 | 16 | 20 |
| 21–30 | | 12 | 8 | 16 | 14 |
| 31–40 | | 14 | 12 | 12 | 10 |
| 41–50 | | 10 | 8 | 12 | 14 |
| 51–60 | | 12 | 8 | 12 | 10 |
| 61–70 | | 14 | 18 | 10 | 8 |
| 71–80 | | 10 | 16 | 6 | 13 |
| 81–90 | | 10 | 12 | 6 | 5 |
| 91–100 | | 4 | 20 | 8 | 5 |
| Mean ± SD | | 44.22 ± 27.58 | 59.9 ± 28.06 | 41.11 ± 28.01 | 40.91 ± 27.44 |

psychosis in vulnerable patients, particularly those with bipolar disorder, dissociative disorders, or schizophrenic spectrum illnesses (Brown and Gerbarg, 2005b). Rapid or forceful breathing practices such as Bhastrika (Bellows breath) can trigger manic episodes in patients suffering from BPAD (Brown et al., 2013). Furthermore rapid breathing can increase the rate of lithium excretion which might have required a change of the lithium dose in some patients (Brown and Gerbarg, 2005b).

Because of difficulty in proving which component of a multi-component intervention was responsible for an outcome, in current study no asanas, meditations or any other kind of intervention (apart from SK&P) was provided to participants.

Statistically significant improvement in anxiety scores of study participants was consistent with findings of earlier studies that yoga programs that include yoga postures and meditation have shown benefits in medical patients with anxiety disorders (Miller et al., 1995) and in medical students with examination anxiety (Malathi and Damodaran, 1999).

The findings of the current study are also similar to those of earlier studies that SK&P led to decreased levels of psychological distress (Brown et al., 2013; Janakiramaiah et al., 2000). Among various subcomponents of SKP, Pranyama can rapidly bring the mind to the present moment and reduce stress (Brown and Gerbarg, 2009). Though earlier studies had reported beneficial

effects of SK&P or its specific components on sleep, mental alertness (Tells and Desiraju, 1992) and overall quality of life (Sharma et al., 2003), these aspects were beyond the scope of this study.

Ujjayi breathing increases parasympathetic activity through vagal afferent inputs to the brain and improves heart rate variability (HRV) (Tells et al., 1993).

Low score in the dimension of total GAF, GH and VT which cannot be completely explained by a diagnosed psychiatric disorder points toward subsyndromal morbidity (Sureka et al., 2013) in these patients but since no specific scale was applied to assess subsyndromal morbidity, this aspect cannot be conclusively commented upon.

SK&P might be a suitable alternative for patients who are unwilling to take medication. Compliance with SK&P ranges from 56 to 80% compared to 50% compliance with prescription antidepressants (with complaints of significant side effects from medication) (Tasman et al., 2003).

Due to the limitation of sample size in this study relation of individual psychiatric disorder with SK&P was not studied. Also, being a prison hospital based study including only male prisoners, the results cannot be applied to the general population. Larger studies with more diverse populations are needed in order to extrapolate these findings to a more general population. As

Table 6
Comparison of difference in pre and post intervention score of study and control participants.

| | Difference in pre and post intervention score in study participants | Difference in baseline and post 6 weeks score in control participants | <i>t</i> | Standard Error of difference | <i>p</i> | Cohen's 'd' |
|--|---|---|----------|------------------------------|----------|-------------|
| <i>Global assessment of functioning (GAF)</i> | | | | | | |
| –6 to –10 | 0 | 19 | 18.29 | 0.687 | <0.01* | 2.41 |
| –1 to –5 | 0 | 48 | | | | |
| 0–5 | 22 | 37 | | | | |
| 6–10 | 24 | 11 | | | | |
| 11–15 | 32 | 0 | | | | |
| 16–20 | 37 | 0 | | | | |
| Mean ± SD | 11.56 ± 5.71 | –1 ± 4.65 | | | | |
| <i>Anxiety (ANX)</i> | | | | | | |
| –6 to –10 | 15 | 0 | 6.05 | 0.76 | <0.01* | 0.80 |
| –1 to –5 | 14 | 59 | | | | |
| 0–5 | 25 | 44 | | | | |
| 6–10 | 28 | 12 | | | | |
| 11–15 | 33 | 0 | | | | |
| Mean ± SD | 4.83 ± 7.22 | 0.25 ± 3.71 | | | | |
| <i>Depressed mood (DEP)</i> | | | | | | |
| –1 to –5 | 45 | 77 | 2.83 | 0.59 | <0.01* | 0.37 |
| 0 to 5 | 42 | 12 | | | | |
| 6 to 10 | 28 | 28 | | | | |
| Mean ± SD | 1.71 ± 4.32 | 0.04 ± 4.62 | | | | |
| <i>Positive well being (PWB)</i> | | | | | | |
| –1 to –5 | 37 | 68 | 4.14 | 0.66 | <0.01* | 0.55 |
| 0 to 5 | 41 | 29 | | | | |
| 6–10 | 24 | 13 | | | | |
| 11–15 | 13 | 5 | | | | |
| Mean ± SD | 3.07 ± 5.33 | 0.34 ± 4.64 | | | | |
| <i>Self control</i> | | | | | | |
| –6 to –10 | 0 | 27 | 0.17 | 0.66 | 0.87 | 0.02 |
| –1 to –5 | 64 | 30 | | | | |
| 0 to 5 | 38 | 29 | | | | |
| 6 to 10 | 13 | 29 | | | | |
| Mean ± SD | 0.08 ± 3.80 | –0.03 ± 5.95 | | | | |
| <i>General health (GH)</i> | | | | | | |
| –1 to –5 | 57 | 63 | 2.78 | 0.58 | <0.01* | 0.37 |
| 0 to 5 | 24 | 38 | | | | |
| 6 to 10 | 25 | 14 | | | | |
| 11 to 16 | 9 | 0 | | | | |
| Mean ± SD | 1.79 ± 4.99 | 0.18 ± 3.70 | | | | |
| <i>Vitality (VT)</i> | | | | | | |
| –1 to –5 | 48 | 55 | 1.04 | 0.60 | 0.30 | 0.14 |
| 0 to 5 | 34 | 33 | | | | |
| 6 to 10 | 33 | 27 | | | | |
| Mean ± SD | 1.76 ± 4.58 | 1.14 ± 4.47 | | | | |
| <i>Total Psychological general well being (PGWB)</i> | | | | | | |
| –1 to –5 | 0 | 65 | 18.44 | 0.84 | <0.01* | 2.43 |
| 0–5 | 16 | 33 | | | | |
| 6–10 | 17 | 17 | | | | |
| 11–15 | 21 | 0 | | | | |
| 16–20 | 22 | 0 | | | | |
| 21–25 | 19 | 0 | | | | |
| 26–30 | 20 | 0 | | | | |
| Mean ± SD | 15.68 ± 8.04 | 0.2 ± 4.05 | | | | |

* *p* value less than 0.05 considered statistically significant.

participants got enrolled in an ongoing SK&P program at various cross sections of time, providing training in SK&P before enrollment in the program was not possible. Some benefits of SK&P could have been possibly minimized due to the time taken by any individual in mastering SK&P technique. Though the therapist spent post session time in correcting SK&P related flaws of various participants, there was no specific mechanism to ensure that each study participant had mastered SK&P.

5.1. Conclusion

The data obtained suggest that practicing SK&P by male prisoners helps in improving GAF, PGWB, PWB and GH of an

individual suffering with non psychotic psychiatric disorder. SK&P also causes significant reduction in anxiety and depression levels of an individual; it also does have a significant effect on VT and SC of an individual. SK&P can be considered as an important additional treatment option in patients suffering from a non psychotic psychiatric disorder.

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